St. Cloud Area School District 742!
Prepare. Engage. Educate. Empower. Inspire.

Health Services Department

District Administration Office
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To: Parents/Guardians
From: Health Services
Re: Entrance into Kindergarten

As you register your child for Kindergarten entrance, we would like you to be aware of the following:

- Minnesota Statute 121A.15 requires all students enrolled in public or private schools to be fully immunized against certain preventable communicable diseases. The attached immunization certificate must be completed and signed by a parent/guardian or physician/healthcare provider. A printed record of immunizations from your child's clinic is acceptable. If you are requesting a non-medical exemption, please use the Student Immunization Form (section 1B) to document your child's status. If you are requesting a medication exemption, please use the Student Immunization Form (section 1A) signed by a health care provider to document your child's status.

- Children entering Kindergarten are generally required to have **five DTaP's** (diphtheria, tetanus, pertussis), **four Polios, two MMR's** (measles, mumps, rubella), **two Varicella** (chickenpox), **and three Hepatitis B vaccinations.** Physician/healthcare providers may recommend a Hepatitis A series. Some variations of the schedule may be acceptable.

- **Two** Varicella (chickenpox) vaccinations, **or proof (month/year) of chickenpox disease** is required for Kindergarten. *A physician/healthcare provider signature is needed in the medical exemption section of the Student Immunization Form (section 2) to verify chickenpox disease.*

- ***These requirements can be waived for children with medical contraindications or parents who's conscientiously held beliefs are opposed to immunizations. If you are requesting an exemption, please use the Student immunization Form (section 1B) to document your child's status. You must check the box of the immunizations your child is to be exempt from and the form must be notarized.***

- Physical examinations are recommended for all Kindergarten students. Please take the physical examination form with you at the time of the examination for the physician/healthcare provider to complete. Please fill in the information at the top of the form prior to the appointment.

- **This immunization and physical form need to be returned to your child's school by AUGUST 15TH.** If the school has not received it by August 15th, you will be contacted by the school nurse. If your child needs medicine at school, additional medication authorization paperwork and a supply of the medication is required. If you have further questions and/or information that you wish to discuss with the school nurse, please feel free to call your child's school.

Thank you,

St. Cloud Area School District 742 Health Services Department

Are Your Kids Ready?

What Minnesota's Immunization Law Requires

Immunization Requirements

Use this chart as a guide to determine which vaccines are required to enroll in child care, early childhood programs, and school (online, home school, public, or private).

Find the child's age/grade level and look to see if your child had the number of shots shown by the checkmarks under each vaccine. The table on the back shows the ages when doses are due.

Birth through 4 years Early childhood programs & Child care	Age: 5 through 6 years (3) For Kindergarten	Age: 7 through 11 years For 1st through 6th grade	Age: 12 years and older For 7th through 12th grade
Hepatitis A (Hep A) ✓			
Hepatitis B (Hep B) ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B ✓✓✓	Hepatitis B (7) ✓✓✓
DTaP/DT ✓✓✓✓	DTaP/DT (4) ✓✓✓✓✓	✓✓✓tetanus and diphtheria containing doses (6)	✓Tdap & DTaP series or catch-up series
Polio ✓✓✓	Polio (5) ✓✓✓✓	Polio (8) ✓✓✓	Polio (8) ✓✓✓
MMR ✓	MMR ✓✓	MMR ✓✓	MMR ✓✓
Hib ✓	It's not too late! If your child has fallen behind on their vaccinations, talk to your doctor or clinic to catch them up.		Meningococcal (ACWY) (9) ✓ & booster
Pneumococcal (1) ✓✓✓✓			
Varicella (2) ✓	Varicella (2) ✓✓	Varicella (2) ✓✓	Varicella ✓✓

Immunizations recommended but not required:

COVID-19
For all children in an eligible age group

Influenza
Annually for all children age 6 months and older

Rotavirus
For infants

Human papillomavirus
At age 11-12 years

(1) Not required after 24 months.

(2) If the child has already had chickenpox disease, varicella shots are not required. If the disease occurred after 2010, the child's doctor must sign a form confirming disease.

(3) First graders who are 6 years old and younger must follow the polio and DTaP/DT schedules for kindergarten.

(4) Fifth shot of DTaP not needed if fourth shot was after age 4. Final dose of DTaP on or after age 4.

(5) Fourth shot of polio not needed if third shot was after age 4. Final dose of polio on or after age 4.

(6) One dose must have been pertussis-containing (i.e., DTaP or Tdap) and one dose must have been given after the fourth birthday. If the first dose in the series was given before age 12 months, then four doses are needed.

(7) An alternate two-shot schedule of hepatitis B may also be used for kids age 11 through 15 years.

(8) At least one dose must have been given after the fourth birthday. If the third dose was given before the fourth birthday, a fourth dose is needed.

(9) One dose of meningococcal ACWY is required beginning at 7th grade. The meningococcal ACWY booster dose is recommended at 16 years and required for 12th grade students.

Exemptions

To enroll in child care, early childhood programs, and school in Minnesota, children must show they've had these immunizations or file a legal exemption.

Parents may file a medical exemption signed by a health care provider or a non-medical exemption signed by a parent/guardian and notarized.

Minnesota Department of Health, Immunization Program

ID# 52799 (1/2022)

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me
on _____ (date)
by _____
(name of parent or guardian)

Notary Signature: _____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF _____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

ST. CLOUD AREA SCHOOL DISTRICT 742 ANNUAL PHYSICAL FORM

If you child needs a sports physical, please use the Minnesota State High School League document or have your healthcare provider print the clinic's sports physical document. Return sports physicals to the school nurse.

Name _____ Male _____ Female _____ Birthdate _____
Address _____ Phone _____
Parent/Guardian _____
Physician/Healthcare Provider _____ Dentist _____
Last physical exam _____ Last dental exam _____

Significant Past History

YEAR		YEAR
Allergy (specify)	Mental Health Condition (specify)	
Asthma	Neurologic (specify)	
Chicken Pox (Disease)	Orthopedic (specify)	
Congenital Defect (specify)	Seizure History	
Developmental Delay	Surgeries (specify) T&A Myringotomy tubes, Hernia	
Diabetes	Vision: Glasses or Contacts	
Hearing	Other	
Heart Condition		

Health Examination

(To be completed by Physician/Healthcare Provider)

Examining Physician's/Healthcare Provider's Name (Print) _____
Ht. _____ Wt. _____ BMI _____ Pulse _____ BP _____ Urinalysis _____ HGB _____

Eyes _____
Ears _____
Nose _____
Throat _____
Glands _____
Lungs _____
Heart _____
Nervous System _____
Orthopedic/Scoliosis _____
Skin _____
Allergies (if so, what?) _____
Nutrition _____
Serious Illnesses _____

Please review immunizations and update for school requirements as needed. Please attach copy of immunization record.
Does student require medication on a daily or episodic routine?
Name of medication: _____
Dose: _____ Frequency: _____
Condition being treated: _____
Please include a separate physician/healthcare provider's order if medication will be taken at school.

Significant Development History _____
History of: Hearing Problem _____ Speech Problem _____
History of: Social or Emotional Problem _____
List conditions which may limit participation in:

A. Classroom Activity _____
B. Physical Education _____
C. Competitive Sports _____

***If child is participating in sports, please complete MSHL sports physical form or provide clinic generated document.
Any special health problems, recommendations and/or comments _____
Immunization(s) given today _____
Approved for: Full Activity _____ Limited Activity _____
Date _____ Examining Physician/Healthcare Provider Signature _____

I hereby release this information to the Health Services Department of District 742 and give the licensed school nurse permission to clarify the information with the Physician/Healthcare Provider if the need arises.

_____
PARENT/GUARDIAN SIGNATURE